BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARVIN L. GIBBS, M.D.** Holder of License No. **13736** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-07-0247A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on April 19, 2007. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of Marvin L. Gibbs, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 13736[1] for the practice of allopathic medicine in the State of Arizona.

3. On August 25, 2006 the Board summarily suspended Respondent's license in case number MD-06-0207A. At its February 2007 meeting the Board considered the Administrative Law Judge's Recommended Order in case number MD-06-0207A and suspended Respondent for "time-served" while he was summarily suspended and placed him on probation.

[1] Respondent's license is currently suspended based on his failure to renew the license.

4. Respondent's license renewal for 2006-2007 was due on August 21, 2006. The four month statutory grace period for renewing the license expired on December 21, 2006. Respondent did not renew his license. Because case number MD-06-0207A and other investigations were pending, Respondent's license did not expire on December 21, 2006. Rather, Respondent's license was suspended by operation of law. A.R.S. § 32-3202.

5. On April 12, 2007 the Board received a complaint alleging on April 10, 2007 Respondent brought a fifty year-old male ("JE") suffering from a priapism to the emergency department. Respondent gave treating staff at the emergency department a verbal and documented history of JE's treatment that led them to believe he was indicating he provided the medications resulting in the priapism. In treating JE at the hospital another physician performed surgery to place a shunt and informed JE he would never have another erection.

6. The Board was also informed that after Respondent was summarily suspended in August 2006 he continued to work at his office five days per week. Respondent would prepare syringes filled with medication and give them to an employee to give as refills to existing patients. A pharmacy survey shows on September 6, 2006 Respondent prescribed 20 ccs Compound/Trimix to himself; on September 15, 2006 Respondent prescribed 200 syringes and needles to himself; and on November 3, 2006 Respondent prescribed 10 ccs of Compound/ST1 to himself. Respondent's summary suspension did not lift until the Board acted on the Administrative Law Judge's Recommended Decision in February 2007. Further, when Respondent failed to renew his license Board Staff informed him his failure to renew had resulted in the suspension of his license.

7. JE informed Board Staff he had been treated by Respondent for erectile dysfunction for approximately seven months and received refills of injectable medication from Respondent's office on September 15, 2006, December 8, 2006, and January 18, 2007. JE's medical record shows the prescription written on September 15, 2006 was signed by a Naturopath, but JE said he

never saw the Naturopath and had never been seen by any physician other than Respondent. JE stated that on at least two occasions after August 25, 2006 he presented to Respondent's office and requested refills from the person working in the front office. This person went to Respondent who filled the injection. The office person then provided the syringe to JE.

8. JE reported he was contacted by cell phone in March 2007 by someone who said he worked for Respondent. This person told JE Respondent no longer had an office, but could still provide medication refills. The cell phone number provided by JE to Board Staff is the cell phone number of Respondent's employee. JE asked the employee for ten injections and the employee told JE to meet him on the corner of 7th Street and McDowell Road in Phoenix, Arizona. JE met the employee in the parking lot and was given ten syringes of medication for which he paid Respondent's employee $120.00.

9. On April 8, 2007 JE developed a priapism and attempted to call Respondent, but the office phone had been disconnected. Two days later, while still suffering from the priapism, JE remembered he had the employee's cell phone number and dialed that number on April 10, 2007. The employee then gave JE Respondent's cell phone number. JE called Respondent who asked him if he had taken Sudafed for the priapism and why he did not contact Respondent sooner. Respondent told JE to go to the emergency department and met him there.

10. JE provided Board Staff with five remaining syringes from those he purchased in the parking lot of 7th Street and McDowell in March 2007. JE also provided an unsigned and undated prescription written on Respondent's prescription pad. The prescription appears to be written in Respondent's hand and is for a stronger dosage than JE had previously received. The triage nurse who first saw JE in the emergency department stated Respondent appeared nervous. The triage nurse also reported that Respondent informed him JE's first injection resulted in a five-hour erection, the second injection went well, and the third resulted in priapism. The triage nurse reported Respondent was adamant about the instructions he gives patients – that they present to

the emergency room in case of priapism. However, JE's treating physician at the hospital reported it was clear to him that JE did not understand he was to present to the emergency room in the event of priapism. JE informed Board Staff Respondent never told him to go to the emergency room in case of priapism. The triage nurse also reported Respondent made a point of telling him his license had been suspended, but then reinstated in August 2006.

11. When interviewed by Board Staff Respondent claimed another physician has covered his patients from November 2006 through the present ("Physician"). Respondent stated his employee has a cell phone that patients call when they have a complication and the employee refers them to Physician or calls Respondent if Physician cannot be reached. Respondent also stated Physician handled all refills. Respondent stated he had not prescribed for patients or dispensed from his office without a current license or dispensing certificate. However, a pharmacy survey shows Respondent prescribed Compound/Trimix on September 6, 2006, prescribed syringes and needles on September 15, 2006, and prescribed compound/ST1 on November 3, 2006. The pharmacy owner could not confirm whether the prescriptions were called in or submitted in written form, but he did recall they were noted "For Office Use Only."

12. Board Staff interviewed Respondent's employee who stated that during the time Respondent was unable to practice patients were instructed to contact him for refills and he would instruct the patients to go to Respondent's office on 40th Street and Bell Road. The employee stated Respondent would empty vials of medications into syringes and give them to him to distribute to patients. The employee stated he worked daily with Respondent until Respondent could no longer pay the rent and the office closed in early 2007.

13. Board Staff interviewed Physician who stated he had only worked on two or three occasions seeing Respondent's patients in November 2006. Physician said he has not been contacted by any of Respondent's patients since November 2006 and he has not written any prescriptions for Respondent's patients since that time. Physician also stated he never wrote a

prescription for a patient of Respondent's that he did not personally see. Physician also specifically stated he did not see JE – this is consistent with JE's statement that he had not seen any physician other than Respondent. A pharmacy survey shows Physician prescribed Compound/Trimix to Respondent's office on twelve occasions from December 8, 2006 through January 23, 2007. The pharmacy confirmed the prescriptions were written "For Office Use Only". Pharmacy records show a second physician prescribed Compound/Trimix on thirteen occasions to Respondent's office from September 9, 2006 through November 1, 2006.

14. There is no evidence in JE's medical record that he was offered any oral medications or other non-invasive means of achieving erections; that he gave adequate informed consent or that he was informed he was to go to the emergency department if he had a priapism. Respondent continued to dispense medications to JE even though JE had no means of contacting Respondent in the event of a complication. Respondent increased JE's dose of Trimix from .12 to .14 without a note or examination indicating his reasons for doing so.

15. The facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 13736 for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a) ("[v]iolating any federal or state laws or rules and regulations applicable to the practice of medicine,") specifically, A.R.S. § 32-3202(A) ("[t]he certificate or license of a health professional who does not renew the certificate or license as prescribed by statute and who has been advised in writing that an investigation is pending at the time the certificate or license is due to expire or terminate does not expire or terminate until the

investigation is resolved. The license is suspended on the date it would otherwise expire or terminate and the health professional shall not practice in this state until the investigation is resolved;") and A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.").

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 13736, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

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DATED this 19th day of April 2007

ARIZONA MEDICAL BOARD

[SEAL]

By _____
Timothy C. Miller, J.D.
Executive Director

ORIGINAL of the foregoing filed this 19th day of April 2007, with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

EXECUTED COPY of the foregoing mailed by US Mail this 19th day of April 2007 to:

Marvin L. Gibbs, M.D.
Address of Record

and

Dean Brekke
Assistant Attorney General
Arizona Attorney General's Office
1275 West Washington, CIV/LES
Phoenix, Arizona 85007

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